MATERNAL SUPPORT SERVICES
RISK SCREENING TOOL

Beneficiary Referred For MSS
❑ **Yes** ❑ **No**

Beneficiary Name: _____ **D.O.B.:** _____
Last First Middle
E.D.C.: _____
Medicaid ID #: _____ **County:** _____
Address: _____ **Telephone:** _____
Beneficiary's Parent/ Guardian/Spouse: _____ **Alternate Telephone:** _____
Additional Contact Person: _____ **Telephone Number:** _____

Health Care (Obstetrical) Provider
Name: _____ **Telephone Number:** _____
Address: _____
Medicaid Health Plan Name: _____

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1. Need for childbirth education
Do you know what to expect at different stages of your pregnancy? ☐ Yes ☐ No
Would you like to learn more about delivery? ☐ Yes ☐ No
Do you have experience in caring for a baby? ☐ Yes ☐ No
Would you like to learn more about how to take care of your baby? ☐ Yes ☐ No

2. Need for transportation to keep medical appointments
How do you get around? ☐ By car ☐ Public transport
How do you plan to get to medical appointments?
_____

3. Need for assistance to care for your infant
Are you good at following directions/instructions? ☐ Yes ☐ No
Barriers: ☐ language ☐ literacy* Education level _____
Physical limitations _____

Describe where you live:
☐ Rent ☐ Own your home ☐ With relatives
☐ Shelter* ☐ Motel* ☐ Car*

4. Nutrition/Health problems
Describe your eating habits
No. of meals eaten per day _____ ☐ Skip meals*
☐ Cook at home ☐ Fast food
Which beverages do you drink often?
☐ Pop ☐ Juice ☐ Water ☐ Milk
Do have any food cravings, e.g. PICA? ☐ Yes* ☐ No
Is your blood low in iron (anemia)? ☐ Yes* ☐ No
Do you have high blood pressure? ☐ Yes* ☐ No
Do you have diabetes now or during other pregnancies? ☐ Yes* ☐ No
Have you had problems with weight gain/loss during your pregnancy? ☐ Yes* ☐ No
Do you have any other health problems that concern you?
Explain _____

5. Family support
Are you under 18 years old? ☐ Yes* ☐ No
Who do you currently live with? _____
Who supported you during pregnancy? _____
Who can you count on for support from?
The baby's father? ☐ Yes ☐ No*
A parent? ☐ Yes ☐ No*
A friend? ☐ Yes ☐ No*
Anyone else? _____

6. Feelings about current pregnancy
Have you been pregnant before? _____
What are your feelings about this pregnancy?
☐ Happy ☐ Unhappy* ☐ Don't Know
Did your last pregnancy result in fetal (womb) or neonatal (within 30 days of birth) death?
☐ N/A ☐ Yes* ☐ No
Have you experienced death of a prior child before age one?
☐ N/A ☐ Yes* ☐ No

7. Mother with cognitive, emotional or mental needs
How are you coping with taking care of your baby?
☐ Good ☐ Bad* ☐ O.K.
Do you feel stressed? ☐ Yes* ☐ No
Do you have a history of postpartum depression? ☐ Yes* ☐ No
Do you have any concerns about your mental or emotional health? ☐ Yes* ☐ No

8. Social situation
Do you worry about somebody mistreating you? ☐ Yes* ☐ No
Do you worry about anyone mistreating your child/children? ☐ Yes* ☐ No
Are you planning on moving during your pregnancy?
☐ Yes ☐ No ☐ Don't Know

9. Use of alcohol, drugs or tobacco products
Do you smoke? ☐ Yes* ☐ No
Do you drink alcohol (beer, wine, liquor) now that you are pregnant? ☐ Yes* ☐ No
Do you use street drugs? ☐ Yes* ☐ No
Does someone in your household use street drugs? ☐ Yes* ☐ No

A Check/Yes response to any asterisk (*) question indicates automatic referral for MSS.

Beneficiary's Name: _____

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10. Other (explain): _____

_____

_____

_____

_____

_____

_____

Completed by: _____ **Date:** _____

INSTRUCTIONS:

1. If the responses to Items 2-10 indicate no other high-risk situation, and responses to questions in Item 1 indicate no experience or knowledge of dealing with pregnancy/baby, the beneficiary needs only Childbirth Education. Enrollment in MSS is not required.
2. Based on the responses to questions for Item 2, assess the need for transportation and, as appropriate, make arrangements to transport beneficiary for appointments.
3. A check/yes response to an asterisk (*) question indicates an automatic referral for MSS. Non-asterisk items should be referred based on provider judgment.

BENEFICIARY:

I understand I may qualify to receive MSS, but I do not want these services.

Signature: _____ **Date:** _____

MEDICAL or MSS CARE PROVIDER

Signature: _____ Date: _____

Print Name: _____

A Check/Yes response to any asterisk (*) question indicates automatic referral for MSS.